		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041889

Facility Name: CARE CENTRE OF CHAMPAIGN

Address: 1915 S. MATTIS (Number) CHAMPAIGN (City) 61821 (Zip Code)

County: CHAMPAIGN

Telephone Number: (847)674-4700 **Fax #** (847)674-4733

IDPA ID Number: 36-4082499

Date of Initial License for Current Owners: 06/01/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DON FIETS **Telephone Number:** (847) 674-4700 X40

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) SECRETARY

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	118	Skilled (SNF)	118	43,188	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	118	TOTALS	118	43,188	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,203	1,203	8
9	SNF/PED					9
10	ICF	18,377	3,267	632	22,276	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,377	3,267	1,835	23,479	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.36%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1,203

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	145,288	6,150	5,912	157,350		157,350		157,350			1
2	Food Purchase		100,936		100,936		100,936	(355)	100,581			2
3	Housekeeping	78,971	22,481		101,452		101,452	72	101,524			3
4	Laundry	43,097	10,173	885	54,155		54,155		54,155			4
5	Heat and Other Utilities			83,908	83,908		83,908		83,908			5
6	Maintenance	32,215	12,440	11,765	56,420		56,420	40	56,460			6
7	Other (specify):*			5,654	5,654		5,654		5,654			7
8	**TOTAL General Services**	299,571	152,180	108,124	559,875		559,875	(243)	559,632			8
	B. Health Care and Programs											
9	Medical Director			9,000	9,000		9,000		9,000			9
10	Nursing and Medical Records	822,896	37,128	117,350	977,374		977,374	12,290	989,664			10
10a	Therapy	40,546	489	4,839	45,874		45,874		45,874			10a
11	Activities	43,653	1,647		45,300		45,300		45,300			11
12	Social Services	22,881			22,881		22,881		22,881			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	929,976	39,264	131,189	1,100,429		1,100,429	12,290	1,112,719			16
	C. General Administration											
17	Administrative	91,687		23,880	115,567		115,567	9,690	125,257			17
18	Directors Fees											18
19	Professional Services			87,006	87,006		87,006	(42,285)	44,721			19
20	Dues, Fees, Subscriptions & Promotions			13,553	13,553		13,553	(3,696)	9,857			20
21	Clerical & General Office Expenses	42,130	13,222	137,044	192,396		192,396	(49,014)	143,382			21
22	Employee Benefits & Payroll Taxes			260,104	260,104		260,104	16,164	276,268			22
23	Inservice Training & Education											23
24	Travel and Seminar			892	892		892	6,081	6,973			24
25	Other Admin. Staff Transportation			2,204	2,204		2,204	7,755	9,959			25
26	Insurance-Prop.Liab.Malpractice			81,965	81,965		81,965	2,229	84,194			26
27	Other (specify):* marketing	10,261			10,261		10,261		10,261			27
28	**TOTAL General Administration**	144,078	13,222	606,648	763,948		763,948	(53,076)	710,872			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,373,625	204,666	845,961	2,424,252		2,424,252	(41,029)	2,383,223			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: CARE CENTRE OF CHAMPAIGN #0041889 **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,912	
	REPAIRS & MAINTENANCE		0	
			0	5,912
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		885	
			0	885
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		16,574	
	ELECTRICITY		35,640	
	WATER		29,854	
	CABLE TV - LOBBY		1,840	
			0	83,908
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,685	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		4,890	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		715	
	FIRE SERVICE		1,475	
			0	
			0	
			0	11,765
7	**OTHER**			
	SCAVENGER		5,654	
	SECURITY SERVICE		0	5,654
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,000	9,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	111,321	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	5,091	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	788	
	PHARMACY CONSULTANT	XVIII B 39-2	150	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	117,350
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		4,616	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	223	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	4,839
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN #0041889 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	23,880	23,880
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	6,434	
	ADMINISTRATIVE CONSULTANTS	XIX C	44,280	
	PROFESSIONAL FEES	XIX C	36,292	
			0	87,006
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	3,723	
	EMPLOYEE WANT ADS	XIX F	5,721	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	556	
	LICENSES & PERMITS	XIX F	3,553	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	13,553
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		83	
	OUTSIDE CLERICAL SERVICES		120,681	
	PENALTIES / OVERDRAFT CHARGES	VI 18	5,414	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		8,603	
	MESSENGER SERVICE		2,263	
			0	137,044

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	102,049	
	UNEMPLOYMENT COMPENSATION	XIX D	36,706	
	WORKERS COMPENSATION INSURANCI	XIX D	58,925	
	HOSPITALIZATION INSURANCE	XIX D	59,845	
	EMPLOYEE BENEFITS - OTHER	XIX D	355	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	2,224	
	CHICAGO HEAD TAX	XIX D	0	260,104
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	680	
	TRAVEL	XIX G	212	
			0	
			0	892
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,204	2,204
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		81,965	81,965
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 845,961

CARE CENTRE OF CHAMPAIGN
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	100,936	PATIENT MEALS	70437
LESS SALES TAX	(355)	ADD EMPLOYEE MEALS	0
NET FOOD	100,581	TOTAL MEALS/YEAR	70437
TOTAL PATIENT CENSUS	23,479	NET FOOD	100581
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	70437
TOTAL PATIENT MEALS	70437	COST PER MEAL	1.43
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN #0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			34,012	34,012		34,012	500	34,512			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,469	14,469		14,469		14,469			32
33	Real Estate Taxes			40,439	40,439		40,439	(520)	39,919			33
34	Rent-Facility & Grounds			150,184	150,184		150,184	4,643	154,827			34
35	Rent-Equipment & Vehicles			450	450		450	347	797			35
36	Other (specify):* STORAGE			1,020	1,020		1,020		1,020			36
37	**TOTAL Ownership**			240,574	240,574		240,574	4,970	245,544			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		42,138	14,667	56,805		56,805		56,805			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			64,782	64,782		64,782		64,782			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		42,138	79,449	121,587		121,587		121,587			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,373,625	246,804	1,165,984	2,786,413		2,786,413	(36,059)	2,750,354			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,255)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(355)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(5,414)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(3,723)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(520)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (11,267)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(24,792)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (24,792)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (36,059)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Page 5A

CARE CENTRE OF CHAMPAIGN

ID# 0041889

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	REAL ESTATE TAX ADJ	(520)	33	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(520)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(355)	0	0	0	0	0	0	0	0	0	0	(355)	2
3	Housekeeping	0	0	72	0	0	0	0	0	0	0	0	72	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	40	0	0	0	0	0	0	0	0	40	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(355)	0	112	0	0	0	0	0	0	0	0	(243)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	12,290	0	0	0	0	0	0	0	0	12,290	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	12,290	0	0	0	0	0	0	0	0	12,290	16
	C. General Administration													
17	Administrative	0	(23,880)	33,570	0	0	0	0	0	0	0	0	9,690	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(44,280)	1,995	0	0	0	0	0	0	0	0	(42,285)	19
20	Fees, Subscriptions & Promotions	(3,723)	0	27	0	0	0	0	0	0	0	0	(3,696)	20
21	Clerical & General Office Expenses	(5,414)	(120,681)	77,081	0	0	0	0	0	0	0	0	(49,014)	21
22	Employee Benefits & Payroll Taxes	0	0	16,164	0	0	0	0	0	0	0	0	16,164	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	6,081	0	0	0	0	0	0	0	0	6,081	24
25	Other Admin. Staff Transportation	0	0	7,755	0	0	0	0	0	0	0	0	7,755	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,229	0	0	0	0	0	0	0	0	2,229	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(9,137)	(188,841)	144,902	0	0	0	0	0	0	0	0	(53,076)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,492)	(188,841)	157,304	0	0	0	0	0	0	0	0	(41,029)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,255)	0	1,755	0	0	0	0	0	0	0	0	500	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	(520)	0	0	0	0	0	0	0	0	0	0	(520)	33
34	Rent-Facility & Grounds	0	0	4,643	0	0	0	0	0	0	0	0	4,643	34
35	Rent-Equipment & Vehicles	0	0	347	0	0	0	0	0	0	0	0	347	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,775)	0	6,745	0	0	0	0	0	0	0	0	4,970	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(11,267)	(188,841)	164,049	0	0	0	0	0	0	0	0	(36,059)	45

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		CERTIFIED HEALTH MGMT	SKOKIE	BKKPG/MGMT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 23,880	CERTIFIED HEALTH MGMT		$	$ (23,880)	1
2	V	21	BOOKKEEPING	120,681				(120,681)	2
3	V	19	ADMIN CONSULTING FEES	44,280				(44,280)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 188,841			$	$ * (188,841)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 72	$ 72	15
16	V	5	ELECTRIC & GAS		" " "		0		16
17	V	6	MAINTENANCE		" " "		40	40	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		12,290	12,290	18
19	V	17	ADMIN SALARIES		" " "		33,570	33,570	19
20	V	19	PROFESSIONAL FEES		" " "		1,995	1,995	20
21	V	20	FEE, SUBSCRIPTIONS		" " "		27	27	21
22	V	21	OFFICE EXP.		" " "		77,081	77,081	22
23	V	22	EMPLOYEE BENEFITS		" " "		16,164	16,164	23
24	V	24	TRAVEL/SEMINAR		" " "		6,081	6,081	24
25	V	25	TRANSPORTATION		" " "		7,755	7,755	25
26	V	26	INSURANCE		" " "		2,229	2,229	26
27	V	30	DEPRECIATION		" " "		1,755	1,755	27
28	V	32	INTEREST		" " "		0		28
29	V	34	OFFICE RENT		" " "		4,643	4,643	29
30	V	35	EQUIPMENT RENTAL		" " "		347	347	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 164,049	$ * 164,049	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	$ 20,487	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 20,487		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	244,189	8	$ 750	$	23,479	$ 72	1
2	5	ELECTRIC & GAS	" " "	244,189	8	0		23,479	0	2
3	6	MAINTENANCE	" " "	244,189	8	420		23,479	40	3
4	10	NURSING/MEDICAL RECORDS	" " "	244,189	8	127,817	127,817	23,479	12,290	4
5	17	ADMIN SALARIES	" " "	244,189	8	349,136	349,136	23,479	33,570	5
6	19	PROFESSIONAL FEES	" " "	244,189	8	20,751		23,479	1,995	6
7	20	FEE, SUBSCRIPTIONS	" " "	244,189	8	285		23,479	27	7
8	21	OFFICE EXP.	" " "	244,189	8	801,665	683,000	23,479	77,081	8
9	22	EMPLOYEE BENEFITS	" " "	244,189	8	168,109		23,479	16,164	9
10	24	TRAVEL/SEMINAR	" " "	244,189	8	63,242		23,479	6,081	10
11	25	TRANSPORTATION	" " "	244,189	8	80,653		23,479	7,755	11
12	26	INSURANCE	" " "	244,189	8	23,179		23,479	2,229	12
13	30	DEPRECIATION	" " "	244,189	8	18,257		23,479	1,755	13
14	32	INTEREST	" " "	244,189	8	0		23,479	0	14
15	34	OFFICE RENT	" " "	244,189	8	48,291		23,479	4,643	15
16	35	EQUIPMENT RENTAL	" " "	244,189	8	3,606		23,479	347	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,706,161	$ 1,159,953		$ 164,049	25

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL				301,905		PRIME+	11,877	6
7	INS FINANCING		X	INS FINANCING							2,592	7
8												8
9	TOTAL Facility Related						$	$ 301,905			$ 14,469	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 301,905			$ 14,469	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 40,534	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 39,828	2
3. Under or (over) accrual (line 2 minus line 1).		$ (706)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 40,625	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 39,919	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	36,193	8
2000	37,086	9
2001	37,948	10
2002	39,229	11
2003	39,828	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CARE CENTRE OF CHAMPAIGN COUNTY CHAMPAIGN

FACILITY IDPH LICENSE NUMBER 0041889

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	45-20-22-282-005	NURSING HOME	$ 39,828.00	$ 39,828.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,828.00	$ 39,828.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,000 B. General Construction Type: Exterior CONCRETE Frame STEEL Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ROOFING			1996	9,253	237	39	237	0	1,985	9
10	SIDEWALK & PATIO			1996	4,146	276	15	276	0	2,281	10
11	DOOR INSTALLED			1996	636	16	39	16	0	130	11
12	HANDRAIL &BUMPER GUARD			1997	2,620	67	39	67	0	477	12
13	FLOOR TILES & CARPETS			1997	19,732	506	39	506	(0)	3,563	13
14	FLOORING, WALLPAPER, CEILING REPAIR			1998	13,669	350	39	350	0	2,395	14
15	ELECTRICAL WORK			1998	7,500	192	39	192	0	1,272	15
16	LANDACAPING			1998	11,551	770	15	770	0	5,005	16
17	DRYWALL/CEILING REPAIR			1999	3,860	99	39	99	(0)	582	17
18	ROOF REPAIR			1999	3,109	80	39	80	(0)	457	18
19	SIDEWALK REPAIR			1999	4,023	268	15	268	0	1,474	19
20	ROOF REPAIR			2000	10,000	364	27.5	364	(0)	1,744	20
21	WALLPAPER			2000	2,440	349	7	349	(0)	1,994	21
22	WALL/CEILING REPAIR			2000	1,425	52	27.5	52	(0)	240	22
23	CURCUIT BREAKERS			2000	710	26	27.5	26	(0)	104	23
24	WALLPAPER/HANDRAILS			2001	7,050	256	27.5	256	0	896	24
25	FLOOR TILE			2001	1,711	62	27.5	62	0	217	25
26	FLOOR BASE/WALLPAPER			2001	1,446	53	27.5	53	(0)	185	26
27	KICKPLATES			2001	995	36	27.5	36	0	126	27
28	HVAC UNIT			2001	3,162	115	27.5	115	(0)	372	28
29	ROOF REPLACEMENT-PARTIAL			2002	25,450	925	27.5	925	0	2,313	29
30	DOME ROOF REPAIR			2002	6,750	245	27.5	245	0	613	30
31	ENTRANCE DOORS			2002	4,193	152	27.5	152	0	380	31
32	LINTEL REPLACEMENT-OUTSIDE			2002	7,500	273	27.5	273	(0)	682	32
33	LINTEL REPLACEMENT-INSIDE			2002	1,800	65	27.5	65	0	163	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BLINDS DINING ROOM/HALLWAYS	2003	$ 6,370	$ 2,420	5	$ 1,274	$ (1,146)	$ 1,911	37
38	ROOF REPLACEMENT	2003	35,900	1,305	27.5	1,305	0	1,958	38
39	DRYWALL REPLACEMENT RES ROOMS	2003	2,650	96	27.5	96	0	144	39
40	ALARM SYSTEM	2003	1,895	69	27.5	69	(0)	103	40
41	FLOORING	2003	7,859	286	27.5	286	(0)	429	41
42	DINING ROOM TABLES/CHAIRS	2003	17,537	638	27.5	638	(0)	957	42
43	KITCHEN FLOORING	2003	1,358	49	27.5	49	0	74	43
44	ALARM SYSTEM	2003	1,605	58	27.5	58	0	87	44
45	GREASETRAP IN KITCHEN FLOOR	2003	2,850	104	27.5	104	(0)	156	45
46	WALL AIR CONDITIONERS	2003	1,833	67	27.5	67	(0)	100	46
47	ALARM SYSTEM	2003	2,698	98	27.5	98	0	147	47
48	ASPHALT RESURFACING	2004	6,750	225	15	225		225	48
49	TILE	2004	4,214	77	27.5	77		77	49
50	ROOF REPAIRS	2004	3,200	58	27.5	58		58	50
51	FLOOR TILE TESTING/REMOVAL	2004	5,500	100	27.5	100		100	51
52	WATER MAIN WORK	2004	800	15	27.5	15		15	52
53	FIRE LINE FOR SPRINKLER	2004	9,975	128	27.5	181	53	181	53
54	CEILING REMOVAL/REPLACEMENT	2004	3,810	69	27.5	69		69	54
55	EXTERIOR EMERG. LIGHT	2004	827	15	27.5	15		15	55
56	SPRINKLER SYSTEM	2004	7,357	134	27.5	134		134	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 279,719	$ 11,844		$ 10,755	$ (1,090)	$ 36,593	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 139,691	$ 14,334	$ 20,695	$ 6,361	5-7YEARS	$ 81,276	71
72	Current Year Purchases	13,050	7,831	1,305	(6,526)	5	1,305	72
73	Fully Depreciated Assets							73
74			1,757	1,757				74
75	TOTALS	$ 152,741	$ 23,922	$ 23,757	$ (165)		$ 82,581	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 432,460	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 35,766	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 34,512	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (1,255)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 119,174	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

PLEASE ENTER ONLY DATES IN CELLS W16 AND W17

1. Name of Party Holding Lease: CARE CENER CHAMPAIGN

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:		118	6/1/96	$ 150,184	25		3
4	Additions							4
5								5
6								6
7	TOTAL		118		$ 150,184 **			7

10. Effective dates of current rental agreement:
Beginning 61/96
Ending 5/31/21

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/05	$ 446,859
13.	12/31/06	$ 457,353
14.	12/31/07	$ 475,892

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 450 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 4,823	$		$ 4,823	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			8,556			8,556	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			1,288			1,288	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				24,715		24,715	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES & Other (specify): LABORATORY	39-2					17,423		17,423	13
14	TOTAL			$		$ 14,667	$ 42,138		$ 56,805	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 117,855)	406,792		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	26,816		6
7	Other Prepaid Expenses	849		7
8	Accounts Receivable (owners or related parties)	240,702		8
9	Other(specify): R/E TAX ESCROW	30,379		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 705,538	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	279,718		15
16	Equipment, at Historical Cost	152,740		16
17	Accumulated Depreciation (book methods)	(167,945)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	345,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 609,513	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,315,051	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 243,584	$	26
27	Officer's Accounts Payable	744,000		27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	301,905		29
30	Accrued Salaries Payable	11,068		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,498		31
32	Accrued Real Estate Taxes(Sch.IX-B)	40,625		32
33	Accrued Interest Payable	285,725		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,636,405	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,636,405	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (321,354)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,315,051	$	48

*(See instructions.)

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (96,425)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (96,425)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(224,929)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (224,929)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (321,354)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,445,130	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,445,130	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	98,621	6
7	Oxygen	16,502	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 115,123	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	110	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 110	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	1,121	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,121	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,561,484	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	559,875	31
32	Health Care	1,100,429	32
33	General Administration	763,948	33
	B. Capital Expense		
34	Ownership	240,574	34
	C. Ancillary Expense		
35	Special Cost Centers	56,805	35
36	Provider Participation Fee	64,782	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,786,413	40
41	**Income before Income Taxes (line 30 minus line 40)****	(224,929)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (224,929)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,000	2,080	$ 56,801	$ 27.31	1
2	Assistant Director of Nursing	1,120	1,152	20,340	17.66	2
3	Registered Nurses	6,301	6,567	136,631	20.81	3
4	Licensed Practical Nurses	5,224	5,469	87,947	16.08	4
5	Nurse Aides & Orderlies	41,365	41,706	475,624	11.40	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,627	1,835	40,546	22.10	8
9	Activity Director	2,236	2,408	24,788	10.29	9
10	Activity Assistants	2,654	2,769	18,865	6.81	10
11	Social Service Workers	1,737	2,065	22,881	11.08	11
12	Dietician					12
13	Food Service Supervisor	2,009	2,180	37,711	17.30	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,060	6,695	60,182	8.99	15
16	Dishwashers	6,202	6,368	47,395	7.44	16
17	Maintenance Workers	1,939	2,115	32,215	15.23	17
18	Housekeepers	10,843	11,103	78,971	7.11	18
19	Laundry	5,191	5,443	43,097	7.92	19
20	Administrator	1,992	2,080	58,522	28.14	20
21	Assistant Administrator	1,936	2,080	33,165	15.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,132	2,488	42,130	16.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,929	2,101	24,540	11.68	31
32	Other Health C: CARE PLAN COO	1,553	1,585	21,013	13.26	32
33	Other(specify) MARKETING	560	560	10,261	18.32	33
34	TOTAL (lines 1 - 33)	106,610	110,849	$ 1,373,625 *	$ 12.39	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	150	$ 5,912	1-3	35
36	Medical Director	750/month	9,000	9-3	36
37	Medical Records Consultant	24	788	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		150	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	5	223	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	179	$ 16,073		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	685	$ 26,710	10-3	50
51	Licensed Practical Nurses	2,575	82,401	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	3,260	$ 109,111		53

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KATHY PICKERING	ADMIN		$ 58,522
BRENDA DIVELY	ASST ADMIN		33,165
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 91,687

B. Administrative - Other

Description	Amount
CERTIFIED HEALTH MGMT	$ 23,880
TOTAL (agree to Schedule V, line 17, col. 3)	$ 23,880
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		87,006
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 87,006

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 58,925
Unemployment Compensation Insurance		36,706
FICA Taxes		102,049
Employee Health Insurance		59,845
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		355
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		2,224
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
MGMT CO ALLOCATION		16,164
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 276,268

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
NONE		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,721
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	3,723
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	3,553
DUES & SUBSCRIPTIONS	556
MGMT CO ALLOCATION	27
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(3,723)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,857

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	212
Seminar Expense	
	680
MGMT CO ALLOCATION	6,081
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,973

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number CARE CENTRE OF CHAMPAIGN # 0041889 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo
Schedule VII)? YES NO If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen
of Public Aid during this cost report period. $ **64,782**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed tc
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services fo
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all othe
times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees